STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 85024-001**
v

Priority Health
Respondent
_____/

Issued and entered
this 7th day of January 2008
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On September 12, 2007, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On September 19, 2007, after an assessment of the material submitted, the Commissioner accepted the request.

At the time of the service at issue here, the Petitioner had health care coverage from Care Choices, a health maintenance organization (HMO). On March 27, 2007, Care Choices surrendered its certificate of authority and is no longer licensed to conduct business as an HMO. Priority Health acquired Care Choices' assets and liabilities and now underwrites Care Choices' coverage. Priority Health handled the Petitioner's grievance and is the Respondent in this external review.

The Commissioner assigned the matter to an independent review organization (IRO) for a review of the medical issues and the IRO sent its recommendation to the Commissioner on October 2, 2007.

II
FACTUAL BACKGROUND

On September 15, 2006, the Petitioner had both a tonsillectomy with fracture and ablation of the inferior turbinates and a uvulopalatopharyngoplasty (UPPP) for the treatment of sleep apnea. Care Choices (hereinafter Priority Health) had pre-authorized coverage for the tonsillectomy but denied retro-authorization and coverage for the hospital charges related to the UPPP.

The Petitioner completed Priority Health's internal grievance process and received its final adverse determination letter dated July 17, 2007.

III
ISSUE

Did Priority Health properly deny coverage for the Petitioner's hospital charges for the UPPP performed on September 15, 2006?

IV
ANALYSIS

Petitioner's Argument

The Petitioner argues that he should not be responsible for charges totaling $2,693.00 because the UPPP surgery was medically necessary. He says he had tried and failed CPAP therapy and his physician recommended the UPPP to treat his sleep apnea.

The Petitioner further says that prior to the surgery, Dr. XXXXX's office assured him that it would contact his insurance carrier to check on coverage and make sure all procedures were covered as one. However, months after the surgery he received a bill for hospital and

anesthesia charges[1] that were not covered. The Petitioner believes he followed appropriate procedures and Priority Health should cover all charges related to the UPPP.

Priority Health's Argument

In its final adverse determination, Priority Health said, "The procedure [i.e., the UPPP] received on September 15, 2006, at XXXXX Hospital was not a covered benefit under your Care Choices HMO contract." To explain its position, Priority Health referred to this provision in the subscriber certificate, the contract that defines the Petitioner's health care benefits:

> **Requirements for Covered Services**
>
> Services covered by HMO must be:
>
> (1) Provided by the PCP or arranged by the PCP or Participating Specialist and approved in advance by HMO, and
>
> (2) Medically necessary, and
>
> (3) A covered benefit, and
>
> (4) Not specifically excluded from coverage, and
>
> (5) Provided by a HMO Participating Provider, except in emergencies. [Underlining added]

Priority Health says that UPPP is specifically excluded from coverage, citing Care Choices' medical policy MS-17, "Obstructive Sleep Apnea Treatment" (in effect at the time of the Petitioner's surgery). The medical policy contains this exclusion (page 3):

> The following procedures/treatments for sleep apnea are *not* covered benefits (this is not an all inclusive list):
>
> * * *
>
> 3. Uvulopalatopharyngoplasty (UPPP)

The medical policy also has this discussion:

> Obstructive sleep apnea syndrome (OSAS) is caused by repetitive obstruction of the upper airway during sleep, resulting in cessation

[1] Priority Health says that only the hospital portion of the UPPP charges are in dispute. The anesthesia charge was paid in error but Priority Health will not seek recovery of that payment.

> of breathing (apnea).
>
> * * *
>
> Palatal surgical procedures tend to alleviate snoring but are not consistently effective in treating sleep apnea. Many patients with sleep apnea have airway obstruction beyond the palatal area that is not treated by soft tissue procedures.

Priority Health explained in its September 20, 2007, position paper that the basis for the exclusion is its belief that a UPPP is a non-standard or unproven procedure for sleep apnea and that "unproven, investigational or experimental procedures, treatments, therapies or drugs" are excluded in the subscriber certificate.

Priority Health says it used Hayes, Inc., an independent technology assessment organization, to assess the efficacy of the procedure and that the Hayes Medical Technology Directory assigned a C rating to UPPP for the treatment of sleep apnea. The directory said:

> The available evidence from the reviewed studies of surgical treatments for sleep apnea suggests that…UPPP…had limited efficacy with MMA providing somewhat better outcomes than the other procedures; however, no randomized trials were identified that evaluated the efficacy of these procedures…relative to nasal CPAP, the standard non-surgical treatment for sleep apnea.

Priority Health believes that the Petitioner's UPPP is not a covered benefit because it is an unproven procedure for sleep apnea and therefore excluded.

Commissioner's Review

The Commissioner first notes that requiring prior authorization of certain services is an important way for a HMO to manage health care utilization and control costs, and that services that require prior authorization should generally not be performed absent a request for authorization. Priority Health has said that Dr. XXXXX's initial request for prior authorization of the tonsillectomy did not include a request for authorization of the UPPP as well. But Priority Health also said in its final adverse determination that the Petitioner "was aware at the time the service was received that this procedure [i.e., the UPPP] would not be considered for payment," indicating that some discussion of coverage had taken place before the surgery and that the

Petitioner (or Dr. XXXXX) was aware of Priority Health's position that coverage for the UPPP would be denied as an unproven service.

It is not apparent from the record, and the Commissioner cannot conclude, that the issue of prior approval was significant in this case. Moreover, from all the material submitted by Priority Health it is clear that its denial was not based on any failure of the Petitioner to get formal prior approval but rather because the procedure was excluded as unproven. Therefore, the Commissioner's decision turns on whether the UPPP is an unproven service and whether it was medically necessary for the Petitioner.

An HMO like Priority Health is required in Chapter 35 of the Insurance Code of 1956 to provide, at a minimum, "basic health services." MCL 500.3519(3). The term "basic health services" is defined in Section 3501 of the Insurance Code, MCL 500.3501, and includes both physician services and ambulatory services such as the Petitioner received. Section 3501 further says that basic health services must be "medically indicated," i.e., medically necessary. HMOs may exclude services and treatment deemed to be unproven, investigational or experimental, and Priority Health denied coverage for the Petitioner's UPPP because it believes it is unproven for the treatment of sleep apnea.

To answer the questions of whether UPPP is unproven and whether it was medically necessary for the Petitioner, the Commissioner assigned the case to an IRO for analysis. The IRO reviewer is board certified in otolaryngology and in head and neck surgery and has been in practice for more than 10 years.

The IRO report said:

> The MAXIMUS physician consultant explained that UPPP has been used as treatment in full or in part of obstructive sleep apnea for at least two decades. The MAXIMUS physician consultant also explained that it has become apparent that multi-site surgery improves outcomes and that anatomy based selection for these procedures is important. The MAXIMUS physician consultant indicated that the member's physician reported that he had nasal airway obstruction, marked tonsillary hyperplasia and a thick long

> uvula. The MAXIMUS physician consultant also indicated that the member underwent surgical correction of these three areas. The MAXIMUS physician consultant explained that this surgery was appropriate and consistent with the standard of care as it addressed both the oropharynx and nasal airway. The MAXIMUS physician consultant also explained that UPPP is not an investigational procedure. [Citations omitted]
>
> Pursuant to the information set forth above and available documentation, the MAXIMUS physician consultant determined that the UPPP that [the Petitioner] underwent was medically necessary for treatment of his condition and was not an investigational procedure.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO recommendation is afforded deference by the Commissioner because it is based on extensive experience, expertise, and professional judgment. The Commissioner can discern no reason why that judgment should be rejected in the present case and finds that Priority Health's denial should be reversed because the UPPP was medically necessary and not an unproven procedure.

V
ORDER

Respondent Priority Health's July 17, 2007, final adverse determination is reversed. Priority Health shall provide coverage for the charges related to the Petitioner's UPPP surgery subject to any applicable terms and conditions of the subscriber certificate regarding surgery.

Priority Health shall provide coverage within 60 days from the date of this Order, and within seven days of providing coverage, shall provide the Commissioner proof it has implemented the Commissioner's Order.

To enforce this Order, the Petitioner must report any complaint regarding the implementation of this Order to the Office of Financial and Insurance Services, Health Plans Division, toll free 877-999-6442.

Priority Health is responsible for processing all Care Choices claims and any appeals under the Patient's Right to Independent Review Act. These changes do not affect the Commissioner's decision and Order in this external review. However, any ongoing correspondence or other actions intended for Care Choices should be directed to Priority Health at this address:

Priority Health
1231 East Beltline SE
Grand Rapids, MI 49525-4501

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.